

<b>Case Number:</b>	CM15-0082193		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	08/04/2013
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 58 year old individual, who sustained an industrial injury on 8/04/2013. Diagnoses include adhesive capsulitis status post left shoulder surgery, cervical thoracic myofascial pain, rule out herniated nucleus pulposus thoracic spine and reactive anxiety/depression. Treatment to date has included diagnostics, orthosis, medications, physical therapy, exercise and TENS unit. Per the Primary Treating Physician's Progress Report dated 3/12/2015, the injured worker reported left shoulder pain rated as 7/10, cervical pain rated as 5/10, thoracic pain rated as 6/10 and low back pain rated as 5/10 on a subjective scale. Physical examination revealed tenderness to the left shoulder with limited range of motion due to pain. There was spasm of the left deltoid musculature/cervical trapezius. The plan of care included, and authorization was requested for Hydrocodone, physical therapy (3x4) for the left shoulder and magnetic resonance imaging (MRI) of the cervical and thoracic spine.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Hydrocodone 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 75, 91, 78-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 74-96.

**Decision rationale:** Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Hydrocodone 10/325mg #60 is not medically necessary and appropriate.

**Physical therapy 3x4 to the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 3x4 to the left shoulder is not medically necessary and appropriate.

**MRI to the cervical and thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Chapter 8 Neck and Upper Back Disorders, Introductory Material, Special Studies and Diagnostic and Treatment Considerations, page(s) 171-171, 177-179.

**Decision rationale:** Submitted reports have not shown any clinical findings of radiculopathy or neurological deficits consistent with any dermatomal distribution of radiculopathy or myelopathy. Per MTUS Treatment Guidelines, criteria for ordering imaging studies are, red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms are persistent; however, none are demonstrated here. Clinical report does not demonstrate such criteria and without clear specific evidence to support the diagnostic study. The MRI to the cervical and thoracic spine is not medically necessary and appropriate.